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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **MONA JEAN SMITH, AKA MONA JEAN WHITE** **501 Heathrow Way** **Stone Mountain, GA 30087** **Registered Nurse License No. 626543** Respondent.	Case No 2012-30 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs (Board).

2. On or about September 22, 2003, the Board of Registered Nursing issued Registered Nurse License Number 626543 to Mona Jean Smith, aka Mona Jean White (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2011, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

STATUTORY PROVISIONS

4. Section 490 of the Code provides, in pertinent part, that a board may suspend or revoke a license on the ground that the licensee has been convicted of a crime substantially related to the qualifications, functions, or duties of the business or profession for which the license was issued.

5. Section 493 of the Code states:

"Notwithstanding any other provision of law, in a proceeding conducted by a board within the department pursuant to law to deny an application for a license or to suspend or revoke a license or otherwise take disciplinary action against a person who holds a license, upon the ground that the applicant or the licensee has been convicted of a crime substantially related to the qualifications, functions, and duties of the licensee in question, the record of conviction of the crime shall be conclusive evidence of the fact that the conviction occurred, but only of that fact, and the board may inquire into the circumstances surrounding the commission of the crime in order to fix the degree of discipline or to determine if the conviction is substantially related to the qualifications, functions, and duties of the licensee in question."

6. Code section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

7. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

8. Code section 2761 provides, in pertinent part:

"The board may take disciplinary action against a certified or licensed nurse ... for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

...

(f) Conviction of ... any offense substantially related to the qualifications, functions, and duties of a registered nurse, in which even the record of the conviction shall be conclusive evidence thereof."

9. Code section 2762 provides, in pertinent part:

"In addition to other acts constituting unprofessional conduct ... it is unprofessional conduct for a person licensed under this chapter to do any of the following:

(a) Obtain or possess in violation of the law, or prescribe, or except as directed by a licensed physician ... any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug ... as defined in Section 4022.

(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

(c) Be convicted of a criminal offense involving the prescription, consumption, or self-administration of any of the substances described in subdivisions (a) and (b) of this section, or the possession of, or falsification of a record pertaining to, the substances described in subdivision (a) of this section, in which event the record of the conviction is conclusive evidence thereof."

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REGULATORY PROVISIONS

10. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

11. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

12. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

DRUG DEFINITIONS

13. Hydromorphone, trade name Dilaudid, is a Schedule II controlled substance pursuant to Health and Safety Code Section 11055(b)(1)(k) and a dangerous drug per Business and Professions Code Section 4022. Dilaudid is a trade name for Hydromorphone.

COST RECOVERY PROVISION

14. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

BACKGROUND FACTS

15. During the time period between September 22, 2003 and May 29, 2009 (date of termination), Respondent was employed as a registered nurse for Loma Linda University Medical Center Center (LLUMCC). During the relevant time period, the Respondent displayed unprofessional behavior during her interactions with several patients in the unit where she worked according to the following:

Patient A

16. With respect to R.O. (Patient A), on or around May 21, 2009, Respondent failed to

follow hospital policy relating to medication management by failing to provide the patient with pain medication at the correct times.

17. Respondent also failed to document the administration of medication in Patient A's Medical Administration Records (MAR).

18. At or around 3:35 p.m., Patient A requested that her dressing be changed. Respondent was asked to change the dressing by her Charge Nurse, G.M., however Respondent failed to do it as ordered.

19. At or around 3:35 p.m., Patient A requested that her portacath needle be changed, but requested that someone other than Respondent do it since Respondent was observed falling asleep on two occasions while administering medication.

Patient B

20. With respect to C.V. (Patient B), Respondent failed to follow hospital policy relating to medication management by failing to provide correct amount of Valium.

21. Respondent also failed to document the administration of medication in Patient B's MAR.

Patient C

22. With respect to T.T. (Patient C), Respondent failed to follow hospital policy relating to medication management by failing to observe the client's physical condition and behavior, signs and symptoms of illness, and provide medication at the appropriate time. As a result the patient complained of "severe pain", cried and wanted to go home.

23. Respondent also failed to document the administration of medication in Patient C's MAR.

24. Respondent's Charge Nurse ordered the Respondent to immediately complete Patient C's discharge documentation however Respondent appeared "dazed "and sleepy and thus

and failed to do it.

Patient D

25. With respect to S.S. (Patient D), Respondent failed to perform essential nursing skills by asking Patient D several health related questions even though the patient had not fully awaken from her surgery.

26. Respondent also appeared confused by the blood pressure readings on the vitals machine, repeatedly pointing to the machine and asking Patient D, "[i]s this your blood pressure?"

27. Respondent appeared "confused" when the Patient D's family asked the Respondent health related questions pertaining to Patient D's condition. As a result Patient D's family felt uncomfortable with Respondent and requested another nurse provide care.

Patient E

28. At all times relevant to the charges herein, LLUMC used a drug dispensing system called the AcuDose System [1]. With respect to D.B. (Patient E), Respondent failed to account for numerous vials and tablets of Hydromorphone (Dilaudid) as summarized below:

Date	Physician Orders	AcuDose Record (Withdrawals)	MAR
5/7/09	Standing Order 2mg hydromorphone, one (1) vial (for injection), every 3 hours.	7:03 a.m.: 2 mg hydromorphone, two (2) vials.	One (1) vial **unaccounted** for in any hospital records.
5/7/09		8:15 a.m.: 2mg hydromorphone, three (3) vials.	Two (2) vials **unaccounted** for in any hospital records.
5/7/09		8:16 a.m.: 4mg hydromorphone, six (6) tablets.	*Withdrawn within one minute of previous withdrawal.*
5/7/09		8:17 a.m.: 4mg	*Withdrawn within*

[1] **AcuDose** is a computerized automated medication dispensing machine. The machine records the user name, patient name, medication, dose, date and time of the withdrawal. The AcuDose is integrated with hospital pharmacy inventory management systems.

		hydromorphone, one (1) tablet.	*one minute of previous withdrawal.*
5/7/09		9:12 a.m.: 2mg hydromorphone, one (1) vial.	*Withdrawn too soon.*
5/7/09		11:16 a.m.: 4mg hydromorphone, seven (7) tablets.	One (1) tablet **unaccounted** for in any hospital records.
5/7/09		12:12 p.m.: 2mg hydromorphone, three (3) vials.	Two (2) vials **unaccounted** for in any hospital records.
5/7/09		2:45 p.m.: 2mg hydromorphone, seven (7) tablets.	One (1) tablet **unaccounted** for in any hospital records.
5/7/09		2:45 p.m.: 4mg hydromorphone, seven (7) tablets.	One (1) tablet **unaccounted** for in any hospital records.
5/7/09		3:03 p.m.: 2mg hydromorphone, one (1) vial.	
5/7/09		4:11 p.m.: 2mg hydromorphone, two (2) vials.	*Withdrawn too soon (1hr. 8min. after previous removal)*
5/7/09		5:32 p.m.: 4mg hydromorphone, seven (7) tablets.	One (1) tablet **unaccounted** for in any hospital records.
5/7/09		6:14 p.m.: 2mg hydromorphone, one (1) vial.	*Withdrawn too soon*
5/8/09		7:42 a.m.: 2mg hydromorphone, three (3) vials.	One (1) vial **unaccounted** for in any hospital records.
5/8/09		9:49 a.m.: 4mg hydromorphone, five (5) tablets.	Order **incorrectly** made for 6 tablets.
5/8/09		9:52 a.m.: 2mg hydromorphone, two (2) tablets.	Two (2) tablets **unaccounted** for in any hospital records.
5/8/09		11:23 a.m.: 2mg hydromorphone, two (2) vials.	One (1) vial **unaccounted** for in any hospital records.
5/8/09		3:20 p.m.: 2mg hydromorphone, two (2) vials.	One (1) vial **unaccounted** for in any hospital records.
5/8/09		3:21 p.m.: 2mg hydromorphone, two (2) vials.	One (1) vial **unaccounted** for in any hospital records.
5/8/09		3:21 p.m.: 2mg	One (1) vial

		hydromorphone, two (2) vials.	**unaccounted** for in any hospital records.

SUMMARY: During the time period between May 7, 2009 and May 8, 2009, Respondent failed to document or account for approximately ten (10) vials of hydromorphone and seven (7) tablets of hydromorphone. Respondent admitted that she had a "bad habit" of not charting during the shift, preferring to wait until the end of the day. Respondent was eventually terminated on or around May 29, 2009 for the medication that she failed to chart.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Incompetence)

29. Respondent is subject to discipline under Code section 2761, subdivision (a)(1) on the grounds of unprofessional conduct as defined under California Code of Regulations, title 16, sections 1443 and 1443.5, in that while working for Loma Linda University Medical Center (LLUMC) as a nurse, Respondent failed to exercise the degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse. Complainant incorporates by reference paragraphs 15 – 28 as if fully set forth herein.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence)

30. Respondent is subject to discipline under Code section 2761, subdivision (a)(1) on the grounds of gross negligence as defined under California Code of Regulations, title 16, section 1442, in that working for LLUMC, Respondent demonstrated an extreme departure from the standard of care, which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse in her documentation of administered medications and in her dealings

with patients, among other reasons. Complainant incorporates by reference paragraphs 15-28 as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(Obtaining or Possessing Controlled Substances)

31. Respondent is subject to discipline pursuant to Code section 2762, subdivision (a), in conjunction with Health & Safety Code § 11055(b)(1)(k) in that on or about May 7 – May 8, 2009, Respondent obtained or possessed controlled substances in violation of the law. Complainant incorporates by reference paragraph 28, as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Conviction of Substantially Related Crime)

32. Respondent is subject to discipline pursuant to Code section 2761, subdivision (f), in that Respondent was convicted of a crime substantially related to the qualifications, functions or duties of a registered nurse.

a. On or about June 20, 2009, Respondent was arrested and charged with violating Veh. Code section 23152(a)[driving under the influence of alcohol] and Veh. Code section 23152(b)[driving while having .08% or higher blood alcohol concentration]. It was further alleged that Respondent had a blood alcohol content of .229%. On or about December 21, 2009, after pleading guilty Respondent was convicted of one misdemeanor count of violating Veh. Code section 23152(b) [driving with blood alcohol concentration of .08% or more] in the criminal proceeding entitled *The People of the State of California v. Mona Jean White* (Super. Ct. County of San Bernardino, 2009, No. TSB903398). Respondent was sentenced to 3 years of probation, with terms and conditions. Respondent was also ordered to complete a nine-month First Offender alcohol and drug counseling program. Respondent was ordered to pay $1,738.00 in fines, fees and restitution.

b. The underlying circumstances occurred on or around June 9, 2009 at approximately 11:05 p.m. when a San Bernardino County Deputy observed Respondent's vehicle stuck on the

center divider on the east and westbound lanes of Highland Avenue in the City of Highland. The driver identified herself as the Respondent. While confronting the Respondent, the deputy detected "a strong odor of an alcoholic beverage" emanating from the Respondent's breath and person. The Respondent admitted to drinking "one bottle of Cisco" merely one hour before driving. The Respondent was then asked to conduct several Standardized Field Sobriety Tests, which she failed. The Respondent was also given a Preliminary Alcohol Screening Test, the results of which indicated that Respondent had a blood alcohol concentration of .229%, nearly three times the limit.

FIFTH CAUSE FOR DISCIPLINE

(Conviction Involving Alcohol)

33. Respondent is subject to discipline pursuant to Code section 2762, subdivision (c), in that Respondent was convicted of a crime involving the consumption of alcohol. Complainant refers to, and by this reference incorporates, the allegations set forth above in paragraph 32 and all subparagraphs, as though set forth fully herein.

SIXTH CAUSE FOR DISCIPLINE

(Use of Alcohol to an Extent or in a Manner Dangerous or Injurious)

34. Respondent is subject to discipline pursuant to Code section 2762, subdivision (b), in that Respondent used and/or was under the influence of alcohol in a manner dangerous or injurious to herself, any other person, or the public. Complainant refers to, and by this reference incorporates, the allegations set forth above in paragraph 32 and all subparagraphs, as though set forth fully herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 626543, issued to Mona Jean Smith, aka Mona Jean White;

2. Ordering Mona Jean Smith to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: July 14, 2011

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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